TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
TEXAS PAIN RELIEF GROUP

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-16-3780

Carrier's Austin Representative
Box Number 54

MFDR Date Received
August 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Texas Mutual is denying these claims due to we only met two of the requirements out of three. However CMS Guidelines only require that you meet two of the three requirements."

Amount in Dispute: $600.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual argues Dr. A. Saidov's 99214 documentation does not meet the CPT criteria for use of that code."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 11, 2016	Evaluation and management services code 99214	$600.00	$170.32

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
3. Insurance Code §1305.153(c) states that "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."
4. Insurance Code §1305.006(3) states that an insurance carrier that establishes or contracts with a network is liable for "health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103."

5. This dispute involves authorized out-of-network services approved by the network in accordance with Insurance Code §1305.006. Accordingly, this request for additional reimbursement is reviewed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 350 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824
   - 890 – DENIED PER AMA CPT DESCRIPTION FOR LEVEL OF SERVICE AND/OR NATURE OF PRESENTING PROBLEMS.
   - W3 – IN ACCORDANCE WITH TDI-DWC RULE 134.804, THIS BILL HAS BEEN IDENTIFIED AS A REQUEST FOR RECONSIDERATION OR APPEAL.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. What is the recommended reimbursement for the disputed professional medical services?
3. Is the requestor entitled to additional reimbursement?

Findings

1. This dispute regards evaluation and management services performed by a non-network provider billed under evaluation and management code 99214.

   Review of information submitted by the respondent finds that the requestor was granted approval by the network to see the injured employee out-of-network for a referral consultation and/or services not available within the network in accordance with Texas Insurance Code §1305.006.

   The insurance carrier denied the disputed services using claim adjustment reason codes 150 – "PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS LEVEL OF SERVICE" and 890 – "DENIED PER AMA CPT DESCRIPTION FOR LEVEL OF SERVICE AND/OR NATURE OF PRESENTING PROBLEMS."

   28 Texas Administrative Code §134.203(b)(1) requires that, for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply Medicare payment policies, including its coding; billing; correct coding (CCI) edits; modifiers; and other payment policies in effect on the date a service is provided, with any additions or exceptions as provided in the rules.

   For the documentation of evaluation and management services, Medicare policy requires the use of the ***1995 Documentation Guidelines for Evaluation and Management Services*** and/or the ***1997 Documentation Guidelines for Evaluation and Management Services***, available from the CMS website at: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf and https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf.

   Procedure code 99214 represents the evaluation and management of an established patient. Additionally, the health care provider billed code 99214 with modifier 25 to indicate that the code represents a significant, separately Identifiable evaluation and management service performed by the same physician on the same date as another procedure or service. Although there is a separately billed procedure code (99000) for specimen collection on the same medical bill for the same date, payment for that procedure is bundled (or included) in the reimbursement for any other services performed on the same date. Code 99000 was not paid by the insurance carrier, is not disputed by the requestor and is not further addressed in this review. Modifier 25 does not affect the reimbursement for evaluation code 99214 under the facts as presented in this dispute.

The definition of evaluation and management code 99214 requires at least 2 of these 3 key components:

- a detailed history;
- detailed examination;
- medical decision making of moderate complexity.

Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies is provided consistent with the nature of the problem(s) and patient needs. The presenting problem(s) are usually of moderate to high severity. A physician typically spends 25 minutes face-to-face with the patient or family.

Review of the submitted medical records finds that the first required key component (a detailed history) is documented—including: an extended history of present illness, complete review of symptoms, and a complete review of past medical, family and social history. In fact, the documentation supports that the higher level of "comprehensive" history is documented; however, as only a detailed history was required, the requestor has more than met the requirements for this key component.

With regard to the second key component (a detailed exam), the documentation supports this also. A detailed examination requires an extended exam of the affected area and other symptomatic or related organ systems up to a total of seven or more. Documentation supports an extended exam of 7 organ systems and the affected area.

Lastly, the third key component (medical decision making of moderate complexity) is not found. The number of diagnoses determined and treatment options reviewed were not extensive. The risk of complications, morbidity and/or mortality were low. When considered in regard with the amount and complexity of diagnostic data reviewed, a decision making level of "low complexity" is supported, but not "moderate."

Nevertheless, only *two* of three key components in the definition of code 99214 are required to be met in order to qualify for the level of service billed—and the health care provider has met those requirements. The insurance carrier's denial reasons are not supported; the submitted documentation supports the service as billed. Reimbursement will therefore be reviewed per applicable division rules and fee guidelines.

2. This dispute regards a referral consultation with a non-network provider approved by the network in accordance with Texas Insurance Code §1305.006. The out-of-network approval letter to treat the injured employee states:

> Our approval is not an agreement to a particular price for the requested service. Bills for network or non-network services are processed in accordance with applicable network contracts or DWC Fee Guidelines and Texas labor Code Section 413.011, and they may be subject to statutory limitations.

No documentation was found to support an applicable contract; reimbursement for the disputed evaluation and management services is therefore subject to the Division's Medical Fee Guideline for Professional Services at 28 Texas Administrative Code §134.203(c), which requires that:

> To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
>
> (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. . . .
>
> (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by a conversion factor. The MAR is calculated by substituting the Division conversion factor. The applicable Division conversion factor for calendar year 2016 is $56.82.

Reimbursement is calculated as follows:

For procedure code 99214, service date January 11, 2016, the relative value (RVU) for work of 1.5 multiplied by the geographic practice cost index (GPCI) for work of 1.005 is 1.5075. The practice expense (PE) RVU of 1.42 multiplied by the PE GPCI of 0.995 is 1.4129. The malpractice RVU of 0.1 multiplied by the malpractice GPCI of 0.772 is 0.0772. The sum of 2.9976 is multiplied by the Division conversion factor of $56.82 for a MAR of $170.32.

3. The total allowable reimbursement for the services in dispute is $170.32. The insurance carrier has paid $0.00. The amount due to the requestor is $170.32.

Conclusion

In resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury, the role of the division is to adjudicate the payment, given the relevant statutory provisions and division rules.

The Division would like to emphasize that the findings and decision in this dispute are based on the information presented by the requestor and respondent available at the time of review. Even though all the evidence was not discussed, it was considered.

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $170.32.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Sec. 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $170.32, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	September 28, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.